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THOUGHT LEADERSHIP

WHY ARE WE RELUCTANT TO EMBRACE APPS?

BY: Dr. Terry McWilliams

Reports projecting growing physician shortages point to greater utilization of Advanced Practice Providers (APPs)[a] to meet future healthcare demands.[1] In addition, the *2017 MGMA DataDive Cost and Revenue Survey* indicates that practices with higher APP-to-physician ratios realize greater net revenues and higher provider productivity.[2] Utilizing APPs to meet healthcare demand while realizing increased profitability and provider productivity seems to be a win-win proposition. So why are we reluctant to embrace the concept?

Let's present the case for APP integration that might compel us to examine existing barriers and ways to effectively work through them … starting with market realities.

We'll start with the care supply and demand issue. Simply stated, demand is outstripping current (and projected) physician capacity. Projections from the Association of American Medical Colleges (AAMC)[1] predict an ongoing concern about physician shortages across most specialties – particularly in primary care and the medicine specialties/subspecialties. "Physician demand continues to grow faster than supply, leading to a projected shortfall of between 40,800 and 104,900 physicians by 2030. The projected shortfall range for 2025 (34,600-82,600) is smaller than the projected shortfall reported in the 2016 report for 2025 (61,700-94,700), reflecting assumptions about faster growth in APRN supply and the recalibration of the model to a 2015 level of care for the starting point of modeling future demand."

The supply of NPs and PAs is growing at a more rapid rate than physicians, as the training cycle is shorter. Many prognosticators indicate that incorporation of APPs into patient care delivery systems will be required to meet the demand for patient care services. The 2017 AAMC report anticipates the increasing integration of APPs in the care delivery mix, stating "[t]he ratio of physicians to APRNs and PAs is projected to fall over time as the APRN and PA supplies grow at faster rates than physician supply. These projections suggest that the physician-to-PA ratio will fall from 7.2:1 in 2015 to 3.5:1 in 2030, and the physician-to-APRN ratio will fall from 3.6:1 in 2015 to 1.9:1 in 2030."

Add enhanced productivity and profitability to the mix. An article[2] about the 2017 MGMA DataDive Cost and Revenue Survey highlights indicates that "[t]he practices with a higher non-physician provider (NPP) to physician ratio (0.41 or more NPPs per full-time equivalent [FTE] physician) earn more in revenue after operating cost than practices with fewer NPPs (0.20 or fewer NPPs per FTE physician) regardless of specialty."[1] This is a pretty significant endorsement for the utilization of APPs. This advantage is echoed by others.[3,4]

However, a significant caveat applies – the APPs must be experienced and must be used at the top of their licenses and capabilities to realize these results. All too often, APPs are employed to fill the roles that reflect a tremendous underutilization of the asset.

And the needed transition to value-based care. The stakes are high. Progressive organizations are shifting their strategies toward value-based care and innovating their care models to reflect the changing demands of the market and position for success. APPs play significant roles in the high-value care models. The APRN (Advanced Practice Registered Nurse) and PA (Physician Assistant) professional societies and other national groups advocate strategic utilization of APPs to not only offset the physician shortage (NPs are estimated to be able to perform approximately 85% of primary care physician tasks and PAs approximately 80%[3]) but to enhance preventive and wellness services delivery, care management, patient education, patient satisfaction, clinical outcomes, and to alleviate physician stress related to "paperwork" [3,4] – all positive contributors in a value-based market.

What are some of the barriers to APP integration?

Physicians lacking a positive, personal frame of reference. I continue to be amazed by the number of physicians who have never worked with an APP – at least knowingly. These individuals do not have a personal foundation from which to build and are often influenced by professional society cautions about APP training, capabilities, and utilization. I was extremely fortunate to be influenced by numerous excellent APPs during my lengthy military family medicine career. Many were key "instructors" and "mentors" during my training years – some of whom I did not even realize were APPs. For instance, I learned well after the fact that two individuals who I thought were the best anesthesiologists at the hospital were actually CRNAs. Certified Nurse Midwives (CNMs) were particularly instrumental in developing my obstetrical labor management and delivery skills – especially since I trained in an era during which natural childbirth was the norm. PNPs were excellent newborn nursery mentors. My positive experiences continued after training. From FNPs to PNPs to CNMs to CRNAs to PAs. All very good, all very capable, and all very personable. This exposure continued in civilian practice – particularly with FNPs in primary care and PAs in emergency departments and surgical practices. Patients and staff loved them. As you can tell, my personal experience strongly biases me in favor of embracing APPs in practice. Unfortunately, this is not the case for many others.

Physicians having a negative, personal frame of reference. It happens, as with any profession, and particularly so with emerging professions in a rapidly changing environment. Reasons for negativity might include a mismatch between expectations and realities, whether based on general expectations or relative experience levels or degrees of autonomy. One example of general expectation mismatches likely occurred during the abrupt "avalanche" of APPs, especially PAs, into teaching hospitals with initiation of the ACGME 80-hour resident work week limitation. Hospitals and health systems scrambled to cover these additional responsibilities – often doing so by employing APPs and often relatively indiscriminately. The immediate impression (and backlash) was that the new work force was not as good as the resident work force and was not able to immediately meet expectations. This unfair expectation and comparison created lingering APP impressions for many. This is one example of mismatches between general expectations of APPs and the reality they can deliver – another issue which is not uncommon.

Relative APP education compared to physicians may contribute to "negative" impressions. APPs receive two years of "medical education" compared to four years of medical school. This leads some to conclude that APPs "can't be" sufficiently educated. Add on the lack of residency training and many physicians dismiss APPs entirely. On the other hand, these distinctions are often offset by the fact that many individuals who become APPs have significant backgrounds in the health professions – backgrounds that most medical students do not possess. This is especially the case for APRNs who receive significant medical and clinical education during their undergraduate years, which is then augmented during their graduate school years. Most APRNs often had significant clinical experience prior to pursuing their advanced degrees (a circumstance that is diminishing as numerous individuals are now pursuing advanced degrees immediately after completing undergraduate studies). These circumstances are often not the case with physicians whose medical education and clinical experience may quite commonly be limited to their medical school years.

Relative APP experience may also contribute to "negative" impressions. APPs are trained but may not be absolutely "ready-to-go" when they complete their education. We often forget that even graduating residents and fellows struggle with the transition from the training environment to independent, attending-level practice. APPs face a similar transition challenge. APPs are more "ready-to-go" when they join primary care practices since the curricula best prepare them for a primary care career. The character of the basic curricula and the lack of residency training thereafter create the need for on-the-job training and mentoring in order to embark in specialty careers outside of primary care. The bottom line is that we should recognize the individuals' strengths and shortcomings and plan accordingly – including the expectation to provide ongoing education and mentoring.

These facets carry over into the third potential mismatch – relative autonomy. This mismatch can present in diametrically opposed ways. One is when the APP is underutilized and is relegated to executing the "supervising physician's" intent – perhaps without context or full information. Information transfer to others in these instances may be incomplete and potentially inaccurate. Questioning the APP messenger may be unfulfilling and give/leave the impression of incompetence – when the root cause is ironically underutilization and under involvement in the patient's care. The opposite issue occurs when APPs are too autonomous, especially early in their transition, and their relative inexperience does not place them on a level playing field with physicians who might expect more than the APP can be realistically expected to deliver.

Then there may be concerns about patient acceptance. Patient acceptance must be a consideration. A decade ago, this was a very legitimate concern. However, we find that most patients have encountered APPs during their healthcare interactions and this barrier is now limited to small pockets of patients. Our clients indicate that patients are as accepting of APPs as any other provider – cautious of any new provider until they establish a trusting relationship. APPs who deliver empathetic, compassionate, "quality" care are readily accepted and embraced – and quickly develop a loyal following … just like physicians across specialties.

Finally, there are regulatory and institutional barriers.

Varying state laws and regulations. States establish the degree of independent practice that APPs can exercise. At this time, all states require supervision of PAs. However, oversight of NPs varies from supervision

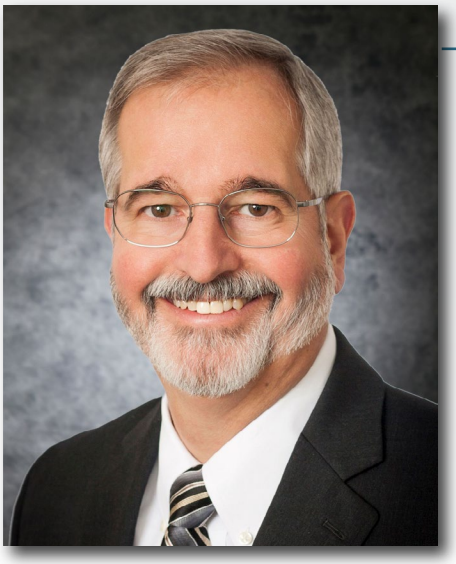
of PAs. However, oversight of NPs varies from supervision similar to PAs to a "collaborative" arrangement with a physician to completely independent practice. As concerns about physician shortages and access to care rise, many experts advocate progressive relaxation of NP oversight restrictions – ironically at the same time that more and more NPs are pursuing their advanced degrees immediately following their undergraduate studies and have less nursing experience. Thus far, doctoral degrees in nursing practice do not seem to confer greater regulatory independence, a situation that could change over time.

State requirements for CRNA supervision also vary by state as CMS permitted states to apply for a waiver of this requirement since 2001. As of August 2016, at least 17 states permit CRNAs to administer anesthesia without physician oversight. This practice is particularly common in rural settings.

Medical Staff Bylaws. Regardless of state regulation requirements, the physician frames of reference discussed above have informed and perpetuated archaic Medical Staff Bylaws that unduly restrict APP practice in our institutions and secondarily impede APP integration into our practices. We need to advocate progressive Bylaws reform to better align them with current clinical realities – yet still protect patients and the institutions.

Organizational time and commitment. Restructuring the care delivery model to fully incorporate APPs requires more than hiring them. Although APPs are the mainstay of care in many communities, others require a significant cultural shift within the practice, the institution, the medical community, and the public during their initial introduction and/or presence expansion. Recognizing areas of resistance, objectively presenting the business case, prudently recruiting qualified candidates, and strategically progressing with implementation are required to be successful in some environments. Sometimes outside assistance is required to guide, mediate, and catalyze this change – a process with which we would be happy to assist.

For the good of our patients, the good of our practices, and the good of the healthcare industry, we need to figure out how to address and overcome our individual issues with APPs so that we can more fully embrace integration of APPs into our clinical practice models and realize the inherent benefits.



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a. Advance Practice Providers (APPs) are also referred to as Advanced Practice Professionals, Advanced Practitioners, or Non-Physician Providers (NPPs) and include Advanced Practice Nurses (APRNs), such as Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs).